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NATIONAL INSTITUTE OF MENTAL HEALTH

National Advisory Mental Health Council

Minutes of the 202nd Meeting

January 17, 2003

Minutes of the 202nd Meeting of the National Advisory Mental Health Council

The National Advisory Mental Health Council (NAMHC) convened its 202nd meeting in closed session for the purpose of reviewing grant applications at 10:30 a.m. on January 16, 2003, in the Neuroscience Center in Rockville, Maryland, and adjourned at approximately 5:45 p.m. (see Appendix A: Review of Applications). The NAMHC reconvened in open session at 8:30 a.m. on January 17, 2003, in Building 31C, Conference Room 10, on the main campus of the National Institutes of Health (NIH) in Bethesda, Maryland. In accordance with Public Law 92-463, this policy meeting was open to the public until its adjournment at 1:00 p.m. Thomas R. Insel, M.D., Director, National Institute of Mental Health (NIMH), chaired the meeting.

Council Members Present at Closed and/or Open Sessions (see Appendix B for Council Roster):

Robert O. Boorstin	<u>Chairperson</u>
Javier I. Escobar, M.D.	
Susan M. Essock, Ph.D.	Thomas R. Insel, M.D.
Susan Folkman, Ph.D.	
Megan R. Gunnar, Ph.D.	<u>Executive Secretary</u>
Renata J. Henry	
Norwood W. Knight-Richardson, M.D.	Jane A. Steinberg, Ph.D.
Henry A. Lester, Ph.D.	
Jeffrey A. Lieberman, M.D.	
James L. McClelland, Ph.D.	
Charles F. Reynolds, III, M.D.	
Elaine Sanders-Bush, Ph.D.	
Larry R. Squire, Ph.D.	
Ming T. Tsuang, M.D., Ph.D.	
Karen Dineen Wagner, M.D., Ph.D.	

Ex-Officio Council Members Present at Closed and/or Open Sessions:

Robert Freedman, M.D., Department of Veterans Affairs
E. Cameron Ritchie, M.D., Department of Defense

Liaison Representative, Substance Abuse and Mental Health Services Administration

Michael J. English, J.D., Center for Mental Health Services (CMHS)

Others Present at the Open Policy Session:

Janet Aker, *The Blue Sheet*
Virginia Anthony, American Academy of Child & Adolescent Psychiatry
Susan Brandon, American Psychological Association
Charles Curie, Substance Abuse and Mental Health Services Administration (SAMHSA)

Deborah DiGilio, American Psychological Association
 Andrea Fiero, National Association of State Mental Health Program Directors
 Cynthia Focarelli, National Mental Health Association
 Della Hann, NIH, Office of Extramural Research
 Louisa Hart, Equals Three Communications
 Kimberly Haynes, Equals Three Communications
 Claire Heffernan, SAMHSA
 Lee Herring, American Sociological Association
 Sally T. Hillsman, American Sociological Association
 Barbara Himmel, Equals Three Communications
 Perry Hoffman, National Education Alliance for Borderline Personality Disorder
 Michael Hogan, Ph.D., Ohio Department of Mental Health
 Thomas Horvath, M.D., Department of Veterans Affairs
 Alan Kraut, American Psychological Society
 Pam Moore, Capitol Publications
 Robert Nichols, American Association for the Advancement of Psychology
 Katherine Nicol, Equals Three Communications
 Dixianne Penney, National Education Alliance for Borderline Personality Disorder
 Tim Perrin, American Association for Geriatric Psychiatry
 Valerie Porr, The Treatment and Research Advancements National Association for Personality Disorder (TARA APD)
 Jerry Reed, Suicide Prevention & Advocacy Network USA
 Stephanie Reed, American Association for Geriatric Psychiatry
 Vicky W. Sain, Suicide Prevention & Advocacy Network USA
 Angela Sharpe, Consortium of Social Science Association
 Jean H. Shin, American Sociological Association
 Lincoln Stanley, American Association for Marriage & Family Therapy
 Adrienne Stith Butler, Institute of Medicine
 Karen Studwell, American Psychological Association
 Barbara Wanchisen, Federation of Behavioral, Psychological and Cognitive Services
 Leslie Weiner, Public Communications
 Zane Wilson, Depression and Anxiety Support Group

NIMH Staff in Attendance:

Joan Abell	Mary Blehar	Rasma Finlayson
Janet Amber	Beth Bowers	William Fitzsimmons
Kathleen Anderson	Linda Brady	Stephen Foote
Bernie Arons	James P. Breiling	Andrew Forsyth
Chiiko Asanuma	Bruce Cuthbert	Ellen Gerrity
Jules Asher	Mark Czarnolewski	Walter Goldschmidts
Karen Babich	Debra Dabney	Margaret Grabb
Elaine Baldwin	Jamie Driscoll	William Harlan
Jean G. Baum	David J. Eskenazi	Timothy C. Hays
Alison Bennett	Wayne S. Fenton	Michael Hirsch

Karen L. Kemp
Doreen Koretz
Israel Lederhendler
Ann Maney
Ernest Marquez
Susan M. Matthews
Annette Mayberry
Robert Mays
Michael J. Moody
Eve Moscicki
Richard K. Nakamura
Jean G. Noronha

Grayson S. Norquist
Jason Olin
Kevin Quinn
Juan Ramos
Dianne M. Rausch
Judith M. Rumsey
Michael Sesma
David Shore
Beth-Anne Sieber
Paul Sirovatka
Melissa Spearing
David Stoff

Ellen L. Stover
Audrey Thurm
Ann Wagner
Marilyn Weeks
Gemma Weiblinger
Kate Whelan
Margaret G. Whittemore
Lois Winsky
Clarissa Wittenberg
Steven J. Zalcman

OPEN POLICY SESSION: Call to Order/Welcome to New Council Members

Thomas R. Insel, M.D., NIMH Director and Chairman, NAMHC, convened the open policy session of the 202nd Council meeting at 8:30 a.m. on January 17, 2003, in Conference Room 10, Building 31C, on the NIH campus in Bethesda, Maryland. After welcoming those present, Dr. Insel introduced four new Council members.

Dr. Susan Essock is a Professor of Psychiatry and Director of the Division of Health Services Research at the Mount Sinai School of Medicine. Prior to joining Mount Sinai in 1998, Dr. Essock was the Director of Psychological Services for Connecticut's public mental health system for 10 years, and she remains a Senior Research Scientist in Connecticut's Department of Mental Health and Addiction Services. Dr. Essock's research has focused on mental health services, managed care, and the cost-effectiveness of specific treatments for mental disorders.

Ms. Renata Henry is the Director of the Division of Substance Abuse and Mental Health for the State of Delaware and has 28 years of experience in mental health and substance abuse research and treatment services, with particular expertise in public health policy. She is currently responsible for community-based and State-operated programs, including the Delaware Psychiatric Center, the only State-operated psychiatric hospital for adults in Delaware.

Dr. Charles Reynolds is a Professor of Psychiatry, Neurology and Neuroscience in the Department of Psychiatry at the University of Pittsburgh School of Medicine. He also is Senior Associate Dean and directs the Mental Health Intervention Research Center for Late-Life Mood Disorders at the Western Psychiatric Institute and Clinic. Dr. Reynolds is internationally renowned for his work in geriatric psychiatry and his extensive research on aging, with a special emphasis on mood and sleep disorders.

Dr. Karen Wagner is the Clarence Ross Miller Professor and Vice Chair of the Department of Psychiatry and Behavioral Sciences at the University of Texas Medical School Branch in Galveston, Texas. She also directs the Division of Child and Adolescent Psychiatry.

Dr. Wagner's research focus has been on child and adolescent psychopharmacology and related cognitive factors.

Approval of the Minutes of the Previous Council Meeting

Dr. Insel requested and received a motion to approve the minutes of the September 13, 2002, NAMHC meeting, which passed unanimously without further discussion.

NIMH Compliance with a Congressional Requirement for Inclusion of Women and Minorities as Subjects in Clinical Studies

Turning to another administrative matter, Dr. Insel noted that the Council is asked to recommend on a biennial basis whether NIMH is in compliance with a congressional requirement regarding the inclusion of women and minorities as participants in Institute-funded studies. Dr. Insel asked Dr. Mary Blehar, Chief, Women's Programs, NIMH Office for Special Populations, to describe the data regarding such participation.

A biennial advisory Council report, Dr. Blehar said, is submitted to Congress through the Office of the NIH Director showing aggregate data for each NIH Institute on the numbers of women and minority member subjects in clinical research studies and demonstrating the efforts made to meet inclusion goals.

Actual enrollment figures for NIMH-supported research during 2001 shows that approximately 54 percent of NIMH subjects were female and 46 percent were male. African Americans represented the largest percentage of minority subjects, followed by Hispanic-Latino and Asian participants. Overall, nearly 43 percent of NIMH clinical study participants reported themselves as members of a minority group.

In response to a question from Council member Dr. Javier Escobar regarding interpretation of data trends, Dr. Blehar said that the aggregate data seem to represent satisfactory implementation of the requirement to include women and minorities in NIMH clinical studies in sufficient numbers to allow valid analyses of differences in intervention effects. However, the aggregate data may not reflect the variance in representation to be found in individual studies.

Dr. Insel asked that a fuller report on the participation of women and minorities be presented at the May Council meeting when time could be set aside for a detailed discussion of the data and their interpretation. A motion indicating NIMH's compliance with the requirement for inclusion of women and minorities in clinical research was made by Dr. Karen Wagner, seconded by Dr. Megan Gunnar, and passed unanimously.

NIMH DIRECTOR'S REPORT

Dr. Insel welcomed the opportunity to work with Institute staff, constituent groups, professional organizations, the general public, and others with an interest in advancing the Institute's mission to

reduce the burden of mental illness and behavioral disorders. Moving into his report, Dr. Insel said he briefly would describe activities in four areas: (1) the NIH Roadmap; (2) outreach activities; (3) highlights of recent research discoveries; and (4) the Institute's budget.

Starting with the Roadmap, Dr. Insel observed that the real challenge, given the leveling out of NIH's research budget following unprecedented growth during the previous 5 years, is to set priorities by formulating a strategic plan to maximize research opportunities and to ultimately reduce the burden of mental illness. In the 8 months since Dr. Elias Zerhouni became NIH Director, the 27 Institutes and Centers that make up NIH have been developing an integrated NIH plan based on a risk-time matrix that categorizes goals according to whether they are high or low risk and short- or long-term—with the higher-risk goals likely to have more impact but also likely to take more time to accomplish. As part of this process, NIMH has suggested several potential goals for the NIH Roadmap and two of them have been accepted:

- Develop molecular libraries, and, by 2010, discover a broad spectrum of small molecules directed at key aspects of cellular machinery; then test at least four of these as therapeutic candidates for treating major mental illnesses. This was established in conjunction with the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and potentially will involve other Institutes.
- Conduct research on depression that, by 2010, will demonstrate a capacity to reduce the total years lost to disability in the United States by 10 percent by: (1) developing better treatment algorithms to improve the management of treatment-resistant depression and (2) elucidating the mechanisms by which depression influences other physical illnesses (e.g., heart disease, Parkinson's disease, cancer, and diabetes).

In addition to the goals included in the overall NIH plan, NIMH is developing its own Roadmap, which remains a work in progress. Two additional proposed goals are as follows:

- Provide, by 2005, the best scientifically obtained estimate of the prevalence and use of services for mental disorders among the major ethnic groups in the United States so as to better direct efforts for reducing health disparities. Accomplishment of this goal will have a real impact on epidemiology and on the planning for service delivery.
- Map, by 2010, at least one gene that produces vulnerability to the major mental illnesses. Even before they contribute directly to therapeutics development, vulnerability genes promise to be vital epidemiological tools for defining risk groups and for narrowing the search for modifiable environmental risk factors.

NIMH has already developed a strategic plan for mood disorders that is detailed in the just-released report, "Breaking Ground, Breaking Through: The Strategic Plan for Mood Disorders Research" (see http://www.nimh.nih.gov/strategic/stplan_moooddisorders.cfm). Two Requests for Applications (RFAs) have been released as spin-offs of this plan: The first with NIDA is for "National Cooperative Drug Discovery Groups for the Treatment of Mood Disorders and Nicotine

Addiction,” and the second is for “Developing Tools for the Assessment of Depression.” The next step is to turn this strategic plan for mood disorder research into a set of priorities that not only specifies what to do but also elaborates a timeline with clear benchmarks for accomplishments.

Turning to outreach plans, Dr. Insel reflected that NIH has generally been encouraged to solicit broad public input on NIH priorities and to be accountable for research investments. A 1998 Institute of Medicine report, “Scientific Opportunities and Public Needs: Improving Priority Setting and Public Input at the National Institutes of Health” (see <http://www.nap.edu/books/030906130X/html/>), stated that NIH has a major responsibility for informing the public about biomedical research as well as responding to the views of various constituencies on research priorities. Another aspect of this responsibility is disseminating research results and health information.

In this spirit, the NIMH Office of Constituency Relations and Public Liaison, directed by Ms. Gemma Weiblinger, oversees NIMH public liaison and outreach activities. Two outreach activities of this Office are noteworthy:

- An annual Research Roundtable provides an opportunity for staff to hear from the advocacy community and tell representatives about exciting discoveries (see <http://www.nimh.nih.gov/events/roundtablemenu.cfm>).
- NIMH has conducted a series of regional forums, or dialogues, both to inform targeted populations about NIMH programs and research and to seek public perspectives and input on needed areas of research. Planning is underway for the next forum “Dialogue Four Corners: Mental Health” that will take place on April 24, 2003, in Albuquerque (see <http://www.nimh.nih.gov/events/fourcorners.cfm>). This is the latest in a series of such meetings that NIMH has held in Alaska, Texas, Chicago, and Pittsburgh. See the NIMH home page (<http://www.nimh.nih.gov/events/townmeetings.cfm>) for information on the earlier meetings.

Turning to research highlights, Dr. Insel said that although many research projects are coming to fruition, one area of the neuroscience portfolio concerning studies of learning and memory is particularly noteworthy. Discoveries pertaining to the molecular basis of learning and memory, as well as to the cellular and systems bases of learning and memory, have great potential for translational research that may well be applicable in the clinic in the near future. Two examples of recent research are particularly exciting: discoveries about the neurophysiology of fear conditioning and extinction and about the potential impact of naturally occurring variations in the valine/methionine (*val/met*) alleles of the brain-derived neurotrophic factor (BDNF) gene on learning and memory.

There is probably no more important area for psychopathology, in terms of learning and memory, than the study of fear conditioning, or fear learning. This area provides fertile ground for examining the neurobiology of anxiety. The process of fear conditioning can be reversed when a human being—or a rat—habituates, or de-conditions, through a process known as extinction. We are now beginning to understand that extinction is a form of learning, not just forgetting, and that

extinction is the key to overcoming fear and is a process that most people employ all of the time. Extinction may be a process that people with post-traumatic stress disorder (PTSD) or phobias are unable to employ. A recent insight into extinction is that it may not involve the amygdala, which is critical for conditioning in a central way but rather that it involves other areas of the brain that feed into the amygdala.

A recent article by Drs. Mohammed Milad and Gregory Quirk (see Milad, M and Quirk, G: Neurons in medial prefrontal cortex signal memory for fear extinction. *Nature*, 420:70-74, November 2002) examined this possibility in a very imaginative way. Using rats as subjects and employing the fear-conditioning paradigm followed by the extinction paradigm on day one and then employing the extinction paradigm again 24 hours later, Drs. Milad and Quirk made a crucial observation: A group of cells in the infralimbic cortex had not responded to the fear conditioning on day one—but 24 hours later, in coordination with the extinction experience, this group of cells had a very high rate of spiking, indicating the learning of extinction. The investigators performed additional experiments where they removed the area in the infralimbic cortex area where the cell group was located reasoning that, if cells in this area were essential for remembering the extinction process, then destroying these cells should render the rats incapable of remembering. Essentially, the rats would appear to have PTSD or a phobia—and continue to show strong fear responses. That is exactly what the investigators found. Then, to reinforce their findings, the investigators stimulated this cell group area in the infralimbic cortex without first performing the extinction trials and concluded that removing this area in the infralimbic cortex reduces extinction, while stimulating it facilitates extinction.

We still believe, Dr. Insel noted, that the amygdala is very important for fear conditioning. However, these investigators demonstrated that the infralimbic cortex, while probably not that vital for the process of fear conditioning or the process of initially learning extinction, plays an important role following extinction by providing a kind of negative gating on the amygdala that seems to reduce subsequent fear behavior. We do not know whether this phenomenon is precisely the same as that which occurs in PTSD, but such a possibility exists.

A second example of an important research breakthrough in the study of learning and memory, Dr. Insel continued, comes from the search for genes producing vulnerability to schizophrenia, an issue discussed by Dr. Daniel Weinberger during his presentation on the catechol-o-methyl transferase (COMT) gene at the September 2002 Council meeting. Another gene of great interest that Dr. Weinberger mentioned—which turned out not to be linked to schizophrenia—is the brain-derived neurotrophic factor (BDNF) that is found on chromosome 11. What makes this gene particularly interesting is a single variation that has been found: a single nucleotide polymorphism (or SNP) at nucleotide 196 that goes from G to A and that changes the amino acid in the protein at that particular point from a valine to a methionine at codon 66. Thus, the BDNF gene can have two variations with two different alleles. As it is not uncommon to find these single nucleotide polymorphisms—they are found throughout the genome at a rate of about one every thousand and most of them do not appear to be functional—the first question that must be asked is whether this variation (BDNF *val66met* allele) has a function.

Several investigators are examining this issue, including Dr. Weinberger, whose article on this topic will be published in *Cell* in the near future (article published following the Council session; see Egan, MF, Kojima, M, Callicott, JH, Goldberg, TE, Kolachana, BS, Bertolino, A, Zaitsev, E, Gold, B, Goldman, D, Dean, M, Lu, B and Weinberger, DR: The BDNF *val66met* polymorphism affects activity-dependent secretion of BDNF and human memory and hippocampal function. *Cell* 112:257-269, January 2003). The study found that the more common BDNF *val* allele entered dendrites more easily than the BDNF *met* allele. Other *in vitro* studies have shown that if the cells are stimulated and the regulated BDNF secretions from dendrites are then examined, the BDNF *met* allele is secreted at a lower rate than the BDNF *val* allele, suggesting that the BDNF *met* allele may be less effective in synaptic responses and in providing changes in synaptic efficiency. Essentially, it appears that this single nucleotide change at the cellular level can impact human behavior. Although it is quite a leap to go from the level of cells in a petri dish to human memory performance, it may be no accident that the small percentage of people who are homozygous—who have both chromosome 11s with the *met* allele—show deficits in memory performance on the revised version of the Wechsler Memory Scale.

These are some of the first studies to investigate the role of single nucleotide variations at many levels. This kind of research, which describes the links between variation in the genome and variation in function, will prove important for understanding the roles of individual genomic differences in mental illness.

Dr. Insel concluded his report by comparing the NIMH and NIH research budgets. When NIMH left NIH and became part of the Alcohol, Drug Abuse, and Mental Health Administration in 1974, its research budget fell considerably below that of NIH and remained relatively flat for a number of years. From 1987 to 1991, the Institute's budget showed a rapid increase. During this period leading up to the Decade of the Brain (the 1990s), budget increases averaged 15 percent to 16 percent a year before leveling off to more normal levels. During the past 5 years, the NIMH budget again increased at a rapid rate—as did the NIH budget. If the 2003 proposed NIH budget is appropriated, the NIMH budget will have increased by about 80 percent over the 1997 level.

Construction of the John E. Porter Neuroscience Research Center, which will eventually house scientists from 10 different NIH components, remains on schedule and within budget for opening in 2004. Work on phase II of the Center currently awaits further budget action. It continues to have the strong support of the NIH Director, Dr. Elias Zerhouni.

Discussion

Dr. Jeffrey Lieberman commented on the potentially negative implications of budget reductions for stimulating new research programs and for supporting new generations of investigators and asked whether the Department of Health and Human Services (DHHS) and Congress fully recognize the potential impact of these economic policies on visions for the future and how difficult it will be to repair already inflicted damage. Dr. Insel responded that the challenge for the future will be to maintain the momentum in the field with available resources. In response to a question from Dr. Charles Reynolds regarding whether the data depicting the evolution of the NIMH and NIH

budgets over a 30-year period were adjusted for inflation, Dr. Insel explained that the data were adjusted for inflation.

Dr. Lester opined that NIH, in accepting a new assignment to fight terrorism, must remain cognizant of the lessons learned from research like that just presented by Dr. Insel demonstrating that there are individual differences among both rats and humans in reactions to fear that are not always extinguished by anti-anxiety medications. Hence, it is of critical importance to continue investigations examining individual differences in fear reactions that might actually paralyze one or more segments of society in response to terrorist acts.

Dr. Insel recalled that Drs. Farris Tuma and Cameron Ritchie reported on the Institute's activities following the events of September 11 at the last Council meeting, stressing the importance of providing effective mental health services for those experiencing terrorist attacks. One aspect of the NIMH mission, which is relevant to the new Department of Homeland Security, is improving an understanding of how best to respond in the aftermath of a terrorist event to reduce fear. In order for the Institute to be able to advise the Nation about the best way to respond to a terrorist event, a much clearer understanding of fear at many levels—from the cellular level through the systems level up to the behavioral level—is required.

CLINICAL TRIALS WORKGROUP

Dr. Jeffrey Lieberman, Professor and Vice Chairman at the Department of Psychiatry, University of North Carolina at Chapel Hill, reported on progress made by the Council's Clinical Trials Workgroup in reviewing the treatment research portfolio of the Division of Services and Intervention Research (DSIR). The Workgroup was asked to examine all project-funding mechanisms (i.e., R01s, collaborative U01s, centers, and contracts) to identify critical knowledge gaps in our research knowledge base, as well as areas of need and scientific opportunity that were not being fully exploited, and to make recommendations regarding ways to address any deficiencies. The Workgroup also was charged with assessing the progress achieved by active grants and contracts and with making recommendations to improve their operation.

Dr. Lieberman reported that the total fiscal year (FY) 2002 expenditures for DSIR treatment trials were more than \$141 million, of which 60 percent provided support for regular investigator-initiated grants, 13 percent provided support for cooperative agreements, and 27 percent provided support for large contract mechanisms. Broken down by specific population segments, \$73 million was spent on studies of adults, \$24 million was spent on geriatric studies and \$54 million supported studies of children. The distribution of funding for adult studies shows that the largest allocation supported studies of depression; smaller allocations supported studies of schizophrenia, anxiety, bipolar disorder, personality disorder, eating/sleep disorders, and other disorders. Like the adult area, the largest proportion of support in the geriatric area was allocated to studies of depression, followed by studies of Alzheimer's disease and schizophrenia, with small allocations supporting studies of anxiety and sleep/eating disorders. For children, the largest allocation was for studies of depression; smaller allocations supported studies of anxiety, bipolar disorder, attention-deficit/hyperactivity disorder, autism, schizophrenia, eating disorder, and other disorders.

Before it delivers a final report, the Workgroup has formulated an interim position statement containing the following highlights:

- Services and intervention research are inherently different from other forms of research funded by NIMH in terms of the scale and the cost of the research projects required to address key public mental health issues. The evolution in research utilizing the range of funding mechanisms recapitulates a developmental course that has successfully been taken by other Institutes, including the National Cancer Institute and the National Heart, Lung, and Blood Institute.
- DSIR's treatment research portfolio reflects a reasonable balance and proportional diversity, with ongoing research studies covering a range of mental disorders and age-relevant populations using a variety of somatic, pharmacological, and psychosocial treatments that are currently or potentially indicated and clinically used for the treatment of mental illnesses and behavioral disturbances.
- There are some areas of redundant research (e.g., electroconvulsive therapy), gaps in areas requiring more study (e.g., treatment adherence and polypharmacy), and continued funding of areas that are viewed as of vestigial importance (e.g., tardive dyskinesia).
- Workgroup members were concerned about the inability of some studies to meet enrollment targets and the level of performance monitoring of funded studies. Steps could be taken to maximize efficiencies in services and intervention research by creating, for example, enduring core resources, procedures, and infrastructures that could provide available resources to extramural investigators who receive awards.

The Workgroup suggested several interim recommendations:

- A process to define priorities and to establish and maintain portfolio balance in treatment research should be developed.
- NIMH should be proactive in defining the research agenda and areas of need in intervention research in mental illness and take the necessary steps to ensure that needed research can be carried out using advisory committees, workshops, and appropriate funding initiatives.
- Core procedures and resources that would facilitate treatment research by the field should be delineated and made available, thus enhancing the quality and efficiencies of the research enterprise.

Recommendations for improving operational procedures and increasing resources include:

- In determining whether to accept any application with direct costs of \$500,000 or more in any year, program staff must consider both the scientific importance and the public health relevance of the proposed research.
- To plan trials that address prioritized scientific and public health needs, investigators should consult with program staff.
- Program staff should develop and use a checklist of operational criteria that all projects must satisfy prior to their submission, including adequacy of study design; site selection; sample size, with adequate gender/minority diversity; and subject recruitment plans.
- Specific application review criteria should be established that can be implemented at the Initial Review Group, Council, and program review levels.
- A coordinating center, a data and safety monitoring board, and data management and analysis units should be established to support multi-site studies.
- A mechanism for monitoring the progress and performance of funded studies should be developed to ensure that the studies are on track or that remedies are implemented to rectify any observed progress limitations.

Discussion

Mr. Michael English commented that the original Workgroup charge was to map the DSIR portfolio to key public mental health issues, and he asked how this would be done. Dr. Lieberman responded that Dr. Ronald Kessler presented his latest survey data on comorbidity to the Workgroup last October and that other epidemiological data are being sought as well so as to ascertain the prevalence of various mental illnesses. Input also is being solicited from a variety of mental health service delivery constituencies, advocacy groups, and public mental health care administrators to identify issues that are important to them. These will be integrated onto a map of public mental health needs.

In response to Dr. Charles Reynolds's questions regarding whether the comorbidity data adequately reflected the mental health needs of Americans aged 60 and older and whether the FY 2002 budget data reflected NIMH's investment in centers and other research infrastructure support, Dr. Lieberman responded that the comorbidity data submitted by Dr. Kessler do include data on elderly individuals and that the funding allocations do include research infrastructure support.

After Dr. Robert Freedman asked how the clinical trials initiative will interface with the goal of developing drugs for newly identified cellular targets, Dr. Lieberman explained that, although the

process of drug discovery and identification of novel therapies is a priority interest, it is not part of this Workgroup's task.

Dr. Megan Gunnar noted that most people being treated for mental illness have a number of comorbid disorders and asked how the Workgroup was handling comorbidity issues.

Dr. Lieberman replied that this is a critical clinical issue and that more research is needed that focuses on primary disorders and common comorbidities.

When Dr. Henry Lester questioned whether the treatment of Parkinson's disease justified the continued support of studies of tardive dyskinesia, Dr. Lieberman explained that with the increasing use of newer medications that have much lower side-effect liability, tardive dyskinesia is less of a clinical problem now and probably requires less research emphasis than other areas of treatment.

Dr. Insel concluded this discussion by noting that the NIH Roadmap includes four cross-cutting themes, one of which is re-engineering the clinical research arena, particularly around clinical trials. The activities of this Workgroup may turn out to be very useful and informative for the NIH subcommittee that is being formed to examine this issue.

SCHIZOPHRENIA AND COGNITION INITIATIVE

Dr. Ellen Stover, Director of the Division of Mental Disorders, Behavioral Research and AIDS (DMDBA), reported briefly on the Measurement and Treatment Research to Improve Cognition in Schizophrenia (MATRICS) contract, which was awarded to the University of California, Los Angeles, in August 2002 (see <http://www.matrics.ucla.edu/>). This project was an outgrowth of recommendations of the Council's Treatment Development Workgroup.

Dr. Wayne Fenton, NIMH Deputy Director for Clinical Affairs in DMDBA and NIMH Associate Director for Clinical Affairs, recalled that schizophrenia was selected as a target for the development of experimental therapeutics because it is an important public health issue and because a great deal of research on the relationship between cognition and this illness already exists.

A Request for Proposals on cognition was issued in January 2002 (see <http://www.nimh.nih.gov/grants/RFPNIMH02DM0006.pdf>) and had the following objectives: (1) promote the development of novel compounds for enhancing cognition in schizophrenia; (2) catalyze regulatory acceptance of cognition in schizophrenia as a target for drug registration; and (3) focus the economic research power of industry on a neglected clinical target.

The MATRICS contract has four deliverables due in the next 12 to 18 months: (1) convene six conferences with expert leaders from industry, academia, and regulatory areas; (2) publish a validated cognitive battery that can be embraced across industry and academia as a way to measure cognition as an endpoint in clinical trials; (3) create, with private companies, a database of potential lead compounds of potential utility in human cognition augmentation trials; and (4) initiate one or

more translational proof-of-concept trials to determine whether a compound can be found that will improve cognition.

Dr. Fenton referenced two upcoming events: a conference on “Neurocognition: Measurement of Cognition as an Endpoint for Drug Registration” to be held on April 14-15, 2003, in Bethesda, Maryland, and a conference on “Neuropharmacology: Translational Implications of Models of Cognition in Schizophrenia” that is scheduled for June 23-24, 2003 (see <http://www.matrics.ucla.edu>).

Plans for FY 2004 are to move forward on the previously approved phase II proof-of-concept clinical trials network that likely will entail five or six small, high-quality, academically based sites using already-developed methods to test identified compounds, select lead compounds, and begin the proof-of-concept trials.

Discussion

Dr. Freedman commented that the treatment development initiative should facilitate the development of a whole new area in the NIMH portfolio—industry’s efforts to develop new treatments for people with mental illness. Dr. Lieberman added that it will be a tremendous achievement if the Food and Drug Administration (FDA) supports the identification of a cognitive endpoint for which drug indications can be obtained. This could have far-reaching effects on motivating and directing the efforts of the pharmaceutical industry as well as on the investigators who are involved in this important quest.

Dr. Lester asked whether it might not be worthwhile to include a representative from the National Institute of Neurological Disorders and Stroke on the Council’s Treatment Development Workgroup, and Dr. Fenton agreed that this was a constructive suggestion.

Dr. Essock commented that it will be particularly challenging to identify the functional consequences of changes in the new neurocognitive measures, noting the controversy generated by the selection of measures, and she asked how the NIMH initiative is addressing this issue. Dr. Fenton replied that this is a critical issue from the scientific and public health perspectives and that consultations with experts in both basic neuropsychology and functional measurement are needed to ensure that any new measure will correlate with a noticeable improvement in patient functioning.

Stressing the likely developmental aspects of schizophrenia, Dr. Gunnar noted that the drug targets may differ, depending on whether they are targeted to prevent symptom emergence or treat symptoms after they have emerged. Because delineating drug targets is a complex task, the consensus conferences should include researchers who are interested in pre-symptom emergence or early life cognitive factors that predict emergence. Dr. Insel agreed that this was an important issue for the Workgroup to consider.

Dr. Insel announced that the first Neurocognition Conference on April 14-15, 2003, coincides with the 50th anniversary of the Nobel Prize-winning discovery of the structure of the DNA double

helix by Drs. James Watson and Francis Crick that launched modern molecular biology. In commemoration, the NIH, in conjunction with the National Human Genome Research Institute, is holding a 2-day celebration on those same dates (see <http://www.genome.gov/10506368>). All of the NIH neuroscience Institutes will collaborate on a follow-up conference, “The Genome and the Brain,” on April 16, 2003.

MEN AND DEPRESSION: A PUBLIC SERVICE ANNOUNCEMENT

Ms. Clarissa Wittenberg, Director of the NIMH Office of Communications, reported on the Institute’s public education campaign “Real Men. Real Depression.” The purpose of this campaign is to increase the public’s awareness of depression in men. Ms. Wittenberg showed a series of 30-second spots that have been developed for use as television public service announcements (PSAs).

Discussion

Dr. Wagner noted the campaign’s relevance to teenaged boys with depression who are at high risk for suicide and who often are unwilling to admit that they have a problem in an effort to hide their vulnerabilities from others. Given that depression runs in families, the campaign also should be helpful by encouraging fathers with depression to openly discuss their depression with their teenaged sons.

Dr. Reynolds added that there is an important connection between depression and suicide among the elderly. Data from the Centers for Disease Control and Prevention document that the highest rates of suicide in the United States are among elderly white males. In approximately 90 percent of cases, suicide is driven by very treatable and often somewhat mild depression. Dr. Reynolds concluded that depression is a problem that crosses many generations and must be considered in the later decades of life.

In response to Dr. Norwood Knight-Richardson’s question about the availability of a Spanish language version of the PSAs, Ms. Wittenberg responded that Spanish versions of the PSAs are not available, although written materials on depression are available in Spanish (see <http://www.nimh.nih.gov/publicat/spanishpub.cfm>).

THE NEW FREEDOM COMMISSION ON MENTAL HEALTH: AN INTERIM REPORT

Mr. Charles Curie, Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) (see <http://www.samhsa.gov/>), opened a presentation on the President’s New Freedom Commission on Mental Health by talking about SAMHSA’s vision and goals for providing quality prevention and treatment services to those suffering from mental illnesses.

SAMHSA’s vision, he said, is one of life in the community for everyone—including those with serious mental illness—a vision consistent with the President’s New Freedom initiative.

Mr. Curie stressed the importance of addressing an individual's life goals—a dependable job, a safe place to live, and a range of social contacts—in the provision of mental health services. He noted that SAMHSA is working to achieve the vision through facilitating recovery and building resilience.

Mr. Curie described three key precepts—accountability, capacity, and effectiveness (ACE)—that underlie SAMHSA's efforts to bring science-based, high-quality, diagnostic, treatment, and prevention services to people of all ages with mental illness in communities nationwide. ACE helps to ensure that programs and activities fulfill their purposes, achieve excellence in service delivery, and benefit the people they serve. In an effort to build resilience and facilitate recovery among those with mental illness, SAMHSA's Center for Mental Health Services (CMHS) supports a number of special initiatives that target populations at risk for mental illnesses and for populations that may not have access to mental health services. Current initiatives include programs that focus on rural mental health, school violence prevention, faith-based mental health, and refugee mental health.

Mr. Curie stressed that SAMHSA's vision and goals to improve the lives of those affected by mental illness are dependent upon a collaborative effort with NIMH, NIDA, and NIAAA to define effective treatment and prevention programs as well as strategies to enhance their translation to community settings. Mr. Curie said that, first, he is working to ensure a smooth transition at SAMHSA from an emphasis on knowledge development and services research to an emphasis on implementing effective community-based substance abuse and mental health service programs. Second, he continued, he is working to help SAMHSA, in conjunction with colleagues at NIMH, NIDA, and NIAAA, reinvigorate and energize each agency's focus on substance abuse and mental health services research and, importantly, disseminate research findings to community treatment settings.

SAMHSA also has a responsibility to identify ways in which emerging community trends can inform the next agenda for substance abuse and mental health research. NIMH, in partnership with CMHS and SAMHSA, helps to bring research to the field by providing the research base from which SAMHSA's projects spring and, in partnership with CMHS, helps to define the most effective and feasible methods for implementing evidence-based practices into State clinical practice settings as well as determining the finances required for those programs. However, information also must come back from the field to inform the services research agenda. SAMHSA seeks to provide direct support to States and localities that are ready and committed to adopting evidence-based practices.

The collaborative efforts of SAMHSA and NIMH are paying dividends. For example, SAMHSA and NIMH announced a joint Request for Applications to promote and support the implementation of evidence-based mental health treatment practices among State mental health systems (see <http://grants.nih.gov/grants/guide/rfa-files/RFA-MH-03-007.html>). Another example of this partnership is NIMH's funding of an application to conduct a formal and objective evaluation of a program of comprehensive community mental health services for children with serious mental health problems and their families. The goal of ongoing collaborations is to speed the translation of cutting-edge information to clinicians and to reduce the 15- to 20-year time period that the

Institute of Medicine estimates is required for research findings to reach the field. Mr. Curie concluded his presentation by noting that the real power of knowledge is unlocked only when it is used to achieve the common good and that is what the science-to-services agenda, undertaken by SAMHSA in partnership with NIMH, NIAAA, and NIDA, is all about.

Dr. Michael Hogan, Director of Ohio's Department of Mental Health and Chair of The President's New Freedom Commission on Mental Health (see <http://www.mentalhealthcommission.gov/index.html>), updated Council on the activities of this body. After introducing the Executive Director of the Commission, Ms. Claire Heffernan, Dr. Hogan provided an overview of the Commission's charge and its activities. President Bush announced the formation of the Commission on April 29, 2002. The Commission, created by an Executive Order signed by the President, was charged with conducting a comprehensive study of problems and gaps in the current mental health service delivery system in the United States, including both public and private providers, and making concrete recommendations for immediate improvements within a year of the mandate.

The Commission was asked to focus on five principles that are listed in the Executive Order:

- The desired outcomes of mental health care, which are to have each individual attain a maximum level of employment, self-care, interpersonal relationships, and community participation.
- The community-level models of care that effectively coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services.
- The policies that maximize the utility of existing resources.
- The ways in which mental health research findings can be used most effectively to influence the delivery of services.
- Following the principles of federalism to ensure that recommendations promote innovation, flexibility, and accountability at all governmental levels.

To accomplish their goals, the Commission members created 15 subcommittees to work on selected tasks and issues (e.g., employment and income, Medicaid and Medicare problems in rural areas, and co-occurring disorders). Each subcommittee is charged with developing an issue paper or specific recommendations. The ultimate goal is to make recommendations about each issue that can—and will—be implemented.

The first product specified in the Executive Order is an interim report that was due and submitted 6 months from the initial charge. Among the report highlights are five barriers to care: (1) fragmentation and gaps in care for children; (2) fragmentation and gaps in care for adults with serious mental illness (SMI); (3) high unemployment and disability among persons with SMI;

(4) lack of care for older adults with mental illnesses; and (5) insufficient acceptance of mental health and suicide prevention as national priorities.

Dr. Hogan commented that the third barrier to care—high unemployment and disability among persons with SMI—is a stunning embarrassment for all of us. Even children with emotional disturbances who are identified and receive specific educational care have the poorest outcomes of any group of students with disabilities. The situation with respect to adults is even worse. Roughly 60 percent of consumers with mental disorders say they want a job and could perform a job with a little assistance—perhaps not 60 hours a week in a high-pressured work situation but in a reasonable work situation. However, people with mental illness have the lowest employment rates among disability groups—ranging from 10 percent to 15 percent. Although persons with mental illness are the second-largest group of disabled people entering the vocational rehabilitation system, they have the worst outcomes and are the largest and fastest-growing group receiving Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) payments. These Federal disability payments for persons with mental illnesses cost approximately \$25 billion a year. This is a particularly appalling situation, as models of supportive employment exist and have demonstrated effectiveness.

With respect to barriers to care, older adults join children and other adults in their lack of access to care. Also, although mental health may not yet be a national priority, the Surgeon General (see <http://www.mentalhealth.org/suicideprevention/>) and the Suicide Prevention Action Network USA, Inc. (see <http://www.spanusa.org/>) have successfully informed the Nation about the toll taken by the 30,000 suicides that occur each year. Suicide may just now be entering our consciousness as a public health issue.

Of particular concern to the Commission is the issue of science-to-service, and the Commission's subcommittee on evidence-based practices (see http://www.mentalhealthcommission.gov/subcommittee/Sub_Chairs.htm) has drafted four interim recommendations:

- Form a federally initiated National Consortium for Leadership that will serve as an infrastructure to expand mental health outreach partnerships and mental health awareness activities, expand professional training for disseminating and implementing evidence-based practices, and promote the recognition of such practices by licensing and accrediting bodies.
- Advance knowledge by strengthening the collaboration between SAMHSA and NIMH in planning, fielding, and evaluating evidence-based practices as well as improving the relevance and generalizability of research (e.g., make clinical trial findings implementable by using tangible structures and processes as bridges between science and services).
- Ensure that funding mechanisms encourage the use of evidence-based practices (i.e., that certain payers, including Medicaid and Medicare, pay for appropriate models of care). For example, collaborative models of care for the elderly have demonstrated effectiveness but Medicare does not cover costs for a caregiver team—it only covers costs for the physician.

- Use the mental health block grant to “seed” evidence-based practices, preferably with additional monies that are carefully targeted to move care models forward.

Discussion

Dr. Knight-Richardson remarked that the Commission faced a daunting task of gathering information from many sources with diverse experience, including consumers of mental health services, family members, mental health professionals and providers, advocates, and other concerned citizens, and then trying to achieve consensus about the recommendations in the final product. Dr. Knight-Richardson praised President Bush’s commitment to enhance the lives of people impacted by mental illness both by recognizing the problems that exist in the current mental health service delivery system and by creating the Commission. HHS Secretary Tommy Thompson, he acknowledged, also is committed to progress in the area of mental illness. Dr. Knight-Richardson cautioned that there would be a logical progression of activities required to implement the recommendations, some of which serve as a template for activities during the next 10 to 15 years.

As the Chairman of the Commission’s cultural competence subcommittee, Dr. Knight-Richardson pledged to make certain that the Commission acknowledges the disproportionate burden of mental illness and fragmented care that impacts cultural and ethnic minority groups. The Commission’s acknowledgement of this cross-cutting issue should be beneficial in getting the necessary resources to these groups.

Ms. Renata Henry opened the discussion by commending Mr. Curie for clarifying SAMHSA’s goals and asked what concrete steps could be taken to reduce the predicted 15 years needed for recommendations to make a difference to 5 years or even 2 years. She noted that the public mental health systems overseen by State mental health program directors are struggling to rapidly and effectively adapt research findings to their delivery systems. Unfortunately, funding issues and the need for providers to develop the necessary knowledge and skills impede the translation of findings. Hence, she encouraged the establishment of concrete goals and measurable objectives to assess the implementation of the Commission’s recommendations.

Acknowledging Ms. Henry’s concern for establishing well-defined outcomes and a timetable for the science-to-services cycle, Mr. Curie reported that Dr. Kevin Hennessey, Health Policy Analyst, Office of the Assistant Secretary for Planning and Evaluation, DHHS, will work with SAMHSA to monitor implementation of this science-to-services cycle. Proof of success will be realized when real demonstration projects are mounted that reflect NIMH findings and when they are implemented to scale, using the block grant monies as seed dollars. Dr. Insel added that an NIMH workgroup has been formed to consult with key staff from SAMHSA. Council will be briefed on the activities of that workgroup at a future meeting.

Dr. Susan Essock stressed the importance of Council’s responsibility to promote evaluation research pertaining to implementing new technologies. As a researcher who has worked in the services area for many years, Dr. Essock said that stressing the importance of adapting clinically significant research findings into everyday clinical practice is not sufficient—the real challenge is

to provide adequate information and training for busy clinicians working in everyday practice settings who believe that they already are providing the highest standards of quality care.

Dr. Essock also cautioned that many people with serious mental health problems will not be helped if the Commissioners limit their recommendations to areas where research evidence exists. For example, while much is known about psychopharmacological interventions for a first episode of various disorders, little research exists regarding the appropriate actions to take if a patient does not respond to a first-line treatment. Innovative approaches to treatment are warranted and may require innovative strategies to stimulate needed research, including targeting funds, providing technical assistance to investigators, and offering other incentives to encourage investigators.

Dr. Karen Wagner said that she was pleased that the Commissioners gave high priority to the significant gaps in care for children with mental illnesses, as attention to the treatment of childhood mental illnesses lags behind that given to adults. One obvious hope is that recognizing and treating these illnesses in children will reduce the level of adult psychopathology. Dr. Knight-Richardson responded that the Commissioners agree that the severe fragmentation of services for children and families is a deterrent to using current knowledge to effect even palliative remedies, much less curative ones, and that this issue will be addressed in the Commission's recommendations.

Dr. Gunnar asked if issues related to prevention and early intervention are being considered by the Commission, and Dr. Hogan replied that one area that will explicitly be examined is earlier intervention with children. Dr. Knight-Richardson added that this issue is addressed in almost all of the subcommittee reports.

OPPORTUNITIES FOR LATE-LIFE MENTAL ILLNESS RESEARCH

Dr. Jason Olin, Chair of the NIMH Aging Research Consortium and Chief of the Geriatric Psychopharmacology Program in DSIR, spoke about the Institute's portfolio on late-life mental illness research and future research directions in this area. He began by noting that the population is rapidly aging, with growing numbers of persons who are over 65 years of age and older, as well as increasing numbers of persons over 85 years of age. By 2030, experts estimate that there will be as many adults 65 years of age and older with major mental illnesses as there are similarly impaired younger adults in the 30- to 44-year-old age range. The number of elderly persons with mental disorders would actually be higher if individuals with Alzheimer's disease were included in these estimates.

During the past decade of late-life research, the field has made major gains in recognizing the importance of the following issues:

- Comorbidity/co-occurrence: Problems do not occur in isolation but rather in tandem with other physical and mental illnesses.
- Function/disability: When older adults seek treatment for mental problems, they are often concerned about their quality of life and disability issues associated with their illness.

- Non-psychiatric settings: Older adults do not typically receive their psychiatric care from psychiatrists in specialty care clinics; they usually see physicians in primary care settings.
- Age of onset of illness: Researchers now know that late onset schizophrenia occurs more frequently in women than in men, who are more likely to be diagnosed during early adulthood.

Dr. Olin also reported that there are about a half-million fewer older Americans in nursing homes than anticipated, based on data and projections from the 1970s. This is due, in part, to better treatment of late-life depression (see Charney, D.S., et al., *Archives of General Psychiatry*, in press, for the results of a recent conference on late-life depression).

Another treatment focus has been on the behavioral problems in Alzheimer's disease—a disorder not only of cognition but also of mood and behavior. Taking the lead from the FDA, NIMH developed criteria to open more targets for treatment, including psychosis, depression, and sleep disturbances accompanying Alzheimer's disease. After a group of prominent investigators set provisional diagnostic criteria for treatment targets, the FDA agreed that a set of consensus-supported criteria, as well as biological evidence to undergird a claim, could support an indication for psychopharmacotherapy. NIMH researchers already have shown an etiological link to neurological illness that, along with these criteria, are leading to more treatments for elderly persons with Alzheimer's disease.

Late-life researchers are investigating agitation in Alzheimer's disease. While numerous compounds are available for treating agitation, evidence is lacking to support which one(s) should be used for this disorder. The Clinical Antipsychotic Trials of Intervention Effectiveness project (see <http://www.catie.unc.edu/>) is comparing several medications in order to provide more evidence regarding which one(s) are most useful for treating agitation.

In summary, Dr. Olin said, the reasons there are about a half-million fewer older Americans in nursing homes may be because clinicians are identifying those who need treatment sooner, more proven treatment options are available, and elderly persons are receiving more of those treatments. Nonetheless, questions remain about priorities for late-life research over the next decade.

Discussion

Dr. Reynolds emphasized that Dr. Olin's presentation needed to be understood in the context of the public health burden of mental illness that is disproportionately borne by older Americans, particularly by members of minority groups. Many studies (e.g., the National Ambulatory Medical Care Survey, see <http://www.cdc.gov/nchs/about/major/ahcd/namcsdes.htm>) consistently reflect a pattern of under-diagnosis and under-treatment of depression among older Americans. While the situation has improved somewhat, thanks to efforts led by NIMH, there is much room for improvement in terms of research and service delivery. Dr. Reynolds volunteered to head a small aging workgroup of Council members to help NIMH staff develop a comprehensive report that would provide a better foundation for Council's deliberations on future late-life research.

Dr. James McClelland commented on the importance of interdisciplinary programs across the NIH Institutes and expressed his enthusiasm for the collaborative potential presented by the new Porter Neuroscience Research Center that is currently under construction at the NIH campus. Research on Alzheimer's disease seems to be a clear case where synergy between Institutes should be promoted. Dr. Insel noted that collaboration across Institutes is something that Dr. Zerhouni has been emphasizing.

PUBLIC COMMENT

Ms. Vicky Sain, representing the Suicide Prevention Action Network USA (SPAN USA), welcomed Dr. Insel, thanked the Council for its support, and offered SPAN USA's support to address the tragic toll that suicide takes on the Nation and the prevention of suicide.

Ms. Cynthia Focarelli, Executive Vice President of the National Mental Health Association (NMHA), applauded the diversity of the NIMH research portfolio with regard to populations and illnesses studied, and she expressed NMHA's hope that this wide-ranging approach would be sustained. She noted that, while PTSD is an illness deserving more attention in these times of general anxiety about the future, she acknowledged that NIMH research should focus on compelling public health problems rather than on specific diagnoses. Resolution of serious public health problems will benefit from increased collaboration between NIMH and SAMHSA. Dr. Insel responded that PTSD is one area of research where rapid progress in translational research is likely. Because the models for genes, systems, and animals already exist, NIMH and SAMHSA may be able to rapidly roll out entirely new approaches to what is a very important public health problem.

Dr. Larry Squire commented that basic neuroscience researchers have a responsibility to explain potential connections between research and clinical concerns as demonstrated by Dr. Insel's presentation on extinction earlier that day. Questions about what drugs and treatments or interventions influence the extinction process are directly relevant to PTSD.

Dr. James Scully, the new Medical Director of the American Psychiatric Association (APA), pledged APA's continued support for improving access to high-quality care for persons with mental illness, for enacting insurance parity legislation, and for working with the New Freedom Commission. In addition, he said, the APA is committed to improving the quality of care afforded to individuals with mental illness by implementing evidence-based treatment guidelines and by working to improve diagnostic schemas.

Ms. Valerie Porr, founder and President of The Treatment and Research Advancements National Association for Personality Disorder (TARA APD), thanked Dr. Insel for his continued support for personality disorder research. However, she commented, the current research support (\$2 million) for this disorder is disproportionate to the 2 to 3 percent of the population affected by personality disorders. Ms. Porr also asked that more attention be given to people with mental illness in the criminal justice system. Dr. Insel responded that the Commission is struggling to realign mental health care to enable people outside of traditional mental health systems to receive needed care.

Dr. Thomas Horvath, a representative of the congressionally chartered Committee for Seriously Mentally Ill Veterans, described the development of the Mental Illness Research, Education, and Clinical Care Center (MIRECC) program. Eight MIRECCs have been developed around the country over the past 5 years as an important component of the Department of Veterans Affairs (VA) infrastructure (see <http://www.mirecc.org/>). Dr. Horvath, also reported that the VA has a new Research Director, Dr. Nelda Wray, from the Houston VA facility, who expects to make the system's research more relevant to veterans' health care needs. The VA is pleased that its investigators have successfully competed for Institute funding and that the investment has paid off as demonstrated by the involvement of the VA in the work described earlier in the day by Drs. Fenton, Stover and Lieberman. Dr. Insel added that the VA has a unique electronic medical record database that centralizes medical records from institutions across the country. That database offers a treasure trove of information for epidemiological studies.

Ms. Deborah DiGilio, with the American Psychological Association's Office on Aging, expressed her support for NIMH's research on late-life disorders. She commended the NIMH Aging Consortium for convening a meeting last fall on geriatric mental health and training and asked that NIMH continue to support research on late-life disorders with a monetary investment that corresponds to the size and mental health needs of the aging population.

Dr. Insel thanked the public participants, Council members, and NIMH staff who participated at this meeting.

Adjournment

Whereupon, the 202nd meeting of the NAMHC adjourned at 12:45 p.m. on January 17, 2003.

I hereby certify that, to the best of my knowledge,
the foregoing minutes are accurate and complete.

Thomas R. Insel, M.D., Chairperson



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